

		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0037366</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Meadowbrook Manor</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/00</u> to <u>12/31/00</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>431 W. Remington Blvd.</u> <u>Bolingbrook</u> <u>60440</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Will</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(630) 759-1112</u> Fax # <u>(630) 759-6579</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IDPA ID Number: <u>363596557001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # <u>(217) 782-1630</u>	
Date of Initial License for Current Owners: <u>11/05/91</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code _____			
<input checked="" type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input checked="" type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact:			
Name: <u>Michael G. Kaplan</u> Telephone Number: <u>312-634-3400</u>			
<u>Altschuler, Melvoin & Glasser LLP</u> <u>One South Wacker Drive</u> <u>Chicago, IL 60606-3392</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Please send copies of any desk review or audit adjustments to the above address.

Facility Name & ID Number Meadowbrook Manor# 0037366 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds 12/01/00

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>235</u>	Skilled (SNF)	<u>298</u>	<u>87,963</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>53</u>	Intermediate (ICF)		<u>17,755</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>288</u>	TOTALS	<u>298</u>	<u>105,718</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>62,102</u>	<u>12,411</u>	<u>7,163</u>	<u>81,676</u>	8
9	SNF/PED					9
10	ICF	<u>8,920</u>	<u>702</u>	<u>132</u>	<u>9,754</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>71,022</u>	<u>13,113</u>	<u>7,295</u>	<u>91,430</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 86.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Day Care

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/05/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 11/05/91NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 54 and days of care provided 6,974Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Meadowbrook Manor

0037366

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	416,013	62,743	22,072	500,828		500,828		500,828		1
2	Food Purchase		435,290		435,290		435,290	(1,899)	433,391		2
3	Housekeeping	225,687	60,571		286,258		286,258		286,258		3
4	Laundry	81,276	37,828		119,104		119,104		119,104		4
5	Heat and Other Utilities			256,418	256,418		256,418	(1,884)	254,534		5
6	Maintenance	90,339	22,016	172,123	284,478		284,478	(1,872)	282,606		6
7	Other (specify):*										7
8	TOTAL General Services	813,315	618,448	450,613	1,882,376		1,882,376	(5,655)	1,876,721		8
	B. Health Care and Programs										
9	Medical Director			12,480	12,480		12,480		12,480		9
10	Nursing and Medical Records	4,137,004	424,780	38,089	4,599,873		4,599,873	(27,610)	4,572,263		10
10a	Therapy	212,162	14,456	13,271	239,889		239,889		239,889		10a
11	Activities	127,211	11,088	4,080	142,379		142,379		142,379		11
12	Social Services	97,899		3,026	100,925		100,925		100,925		12
13	Nurse Aide Training	15,798	3,750		19,548		19,548		19,548		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	4,590,074	454,074	70,946	5,115,094		5,115,094	(27,610)	5,087,484		16
	C. General Administration										
17	Administrative	180,136		28,759	208,895		208,895	(28,759)	180,136		17
18	Directors Fees										18
19	Professional Services			129,216	129,216		129,216	(7,312)	121,904		19
20	Dues, Fees, Subscriptions & Promotions			62,083	62,083		62,083	(900)	61,183		20
21	Clerical & General Office Expenses	386,975	53,699	81,821	522,495		522,495	8,732	531,227		21
22	Employee Benefits & Payroll Taxes			844,452	844,452		844,452	36,020	880,472		22
23	Inservice Training & Education										23
24	Travel and Seminar			6,185	6,185		6,185	68	6,253		24
25	Other Admin. Staff Transportation			2,636	2,636		2,636		2,636		25
26	Insurance-Prop.Liab.Malpractice			122,779	122,779		122,779		122,779		26
27	Other (specify):*										27
28	TOTAL General Administration	567,111	53,699	1,277,931	1,898,741		1,898,741	7,849	1,906,590		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	5,970,500	1,126,221	1,799,490	8,896,211		8,896,211	(25,416)	8,870,795		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Meadowbrook Manor

#0037366

Report Period Beginning:

01/01/00

Ending:

12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7 **	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			97,465	97,465		97,465	387,313	484,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			134,676	134,676		134,676	977,529	1,112,205			32
33	Real Estate Taxes							270,073	270,073			33
34	Rent-Facility & Grounds			3,600,000	3,600,000		3,600,000	(3,592,158)	7,842			34
35	Rent-Equipment & Vehicles			9,305	9,305		9,305		9,305			35
36	Other (specify):*											36
37	TOTAL Ownership			3,841,446	3,841,446		3,841,446	(1,957,243)	1,884,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		314,923		314,923		314,923		314,923			39
40	Barber and Beauty Shops			28,096	28,096		28,096		28,096			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			158,577	158,577		158,577		158,577			42
43	Other (specify):* Nonallowable costs			138,535	138,535		138,535	(138,535)				43
44	TOTAL Special Cost Centers		314,923	325,208	640,131		640,131	(138,535)	501,596			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	5,970,500	1,441,144	5,966,144	13,377,788		13,377,788	(2,121,194)	11,256,594			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(659)	2		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	51,504	30		9
10 Interest and Other Investment Income	(9,119)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(797)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(3,850)	43		18
19 Entertainment				19
20 Contributions	(4,550)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(84,084)	43		24
25 Fund Raising, Advertising and Promotional	(10,056)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax	(2,859)	43		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(100,657)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (165,127)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(1,956,067)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (1,956,067)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (2,121,194)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES		Sch. V Line	
	Amount	Reference	
1	\$		1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
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83			83
84			84
85			85
86			86
87			87
88			88
89			89
90 Total	0		90

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning:

01/01/00

Ending:

12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Dr. Kianoosh Jafari	25.00%	Butterfield Health Care II, Inc.		Seneca Building		
Robert Jafari	25.00%	d/b/a Meadowbrook Manor - Naperville	Naperville	Partnership	Des Plaines	Lessor
Louis William Dimas Family Ltd Ptshp	20.00%			J&D Partners, L.P.	Bolingbrook	Lessor
Nicholas Vangel	20.00%	Seneca Nursing Home, Inc. d/b/a Lee Manor	Des Plaines	MMN Partners, L.P.	Naperville	Lessor
Eva Dimas	10.00%			Butterfield Health Care		
				Mgmt Group, Inc.	St. Charles	Management Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V		3,600,000	J & D Partners, L.P. (Page 6A)	100.00%	1,614,018	(1,985,982)
7	V						
8	V		28,759	Butterfield Health Care Management Group Inc. (Page 6B)	100.00%	58,674	29,915
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$ 3,628,759			\$ 1,672,692	\$ * (1,956,067)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional Services	\$	J & D Partners, L.P	100.00%	\$ 21,507	\$ 21,507	15
16	V	20 Fees & Subscriptions		J & D Partners, L.P	100.00%	215	215	16
17	V	30 Depreciation		J & D Partners, L.P	100.00%	335,575	335,575	17
18	V	32 Interest Expense		J & D Partners, L.P	100.00%	986,648	986,648	18
19	V	33 Real Estate Taxes		J & D Partners, L.P	100.00%	270,073	270,073	19
20	V	34 Rent	3,600,000	J & D Partners, L.P	100.00%		(3,600,000)	20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 3,600,000			\$ 1,614,018	\$ * (1,985,982)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	10 Nursing Consultant	\$	Butterfield Health Care Management Group Inc.	100.00%	\$ 503	\$ 503	15
16	V	17 Management Fees	28,759	Butterfield Health Care Management Group Inc.	100.00%		(28,759)	16
17	V	19 Professional Services		Butterfield Health Care Management Group Inc.	100.00%	449	449	17
18	V	20 License, Fees, & Promotions		Butterfield Health Care Management Group Inc.	100.00%	2,403	2,403	18
19	V	21 General Office Expense		Butterfield Health Care Management Group Inc.	100.00%	8,732	8,732	19
20	V	22 Employee Benefits & Payroll Taxes		Butterfield Health Care Management Group Inc.	100.00%	38,353	38,353	20
21	V	24 Travel & Seminar		Butterfield Health Care Management Group Inc.	100.00%	158	158	21
22	V	30 Depreciation		Butterfield Health Care Management Group Inc.	100.00%	234	234	22
23	V	34 Rent-Facility & Grounds		Butterfield Health Care Management Group Inc.	100.00%	7,842	7,842	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 28,759			\$ 58,674	\$ * 29,915	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES
 ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 0	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Meadowbrook Manor # 0037366 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Jafari	Stockholder	Executive Director	25.00%	41,786	22	54.50	Salary	\$ 49,970	L17,C1	1
2	Nicholas Vangel	Stockholder	Executive Director	20.00%	24,981	22	54.50	Salary	29,874	L17,C1	2
3	Ladan Nili	Purchasing Director	Clerical	0.00%	18,622	22	54.50	Salary	22,269	L21,C1	3
4	Christopher Vangel	Operation Supervisor	Clerical	0.00%	3,096	22	54.50	Salary	3,702	L21,C1	4
5											5
6											6
7			*- Compensation received from only one other nursing home								7
8			which was Butterfield Health Care II, Inc. d/b/a Meadowbrook								8
9			Manor of Naperville								9
10											10
11											11
12											12
13								TOTAL	\$ 105,815		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor# 0037366

Report Period Beginning:

01/01/00Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Butterfield Health Care Management Group, Inc.
 Street Address 4N645 School Road
 City / State / Zip Code St. Charles, IL 60175
 Phone Number (630) 443-8238
 Fax Number (630) 443-9379

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing Consultant	Resident Days	167,872	2	\$ 923	\$	91,430	\$ 503	1
2	19	Professional Services	Resident Days	167,872	2	823		91,430	449	2
3	20	License, Fees & Promotions	Resident Days	167,872	2	4,412		91,430	2,403	3
4	21	General Office Expense	Resident Days	167,872	2	16,036		91,430	8,732	4
5	22	Employee Benefits & Payroll Tax	Resident Days	167,872	2	70,424		91,430	38,353	5
6	24	Travel & Seminar	Resident Days	167,872	2	290		91,430	158	6
7	30	Depreciation	Resident Days	167,872	2	429		91,430	234	7
8	34	Rent-Facility & Grounds	Resident Days	167,872	2	14,440		91,430	7,842	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 107,777	\$		\$ 58,674	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	American National Bank		X	Mortgage	\$126,680.00	05/06/98	\$ 13,806,841	\$ 12,741,938	02/28/08	0.0750	\$ 982,342	1	
2	American National Bank		X	Mortgage	Included in Line 1	05/06/98	1,250,625	1,250,625	02/28/08	0.0750	94,663	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Shareholder Loan	X		Working Capital	N/A	12/14/99	1,500,000	1,500,000	Demand	0.0950	39,241	6	
7	GMAC		X	Equipment Financing	\$720.00	6/04/00	23,641	19,374	06/04/03	0.0850	772	7	
8												8	
9	TOTAL Facility Related				\$127,400.00		\$ 16,581,107	\$ 15,511,937			\$ 1,117,018	9	
	B. Non-Facility Related*												
10								Amortization of Loan Costs			5,400	10	
11								Interest Income - Offset			(10,213)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (4,813)	14	
15	TOTALS (line 9+line14)						\$ 16,581,107	\$ 15,511,937			\$ 1,112,205	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Meadowbrook Manor**# **0037366**

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	225,200	1	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	\$	241,423	2
3. Under or (over) accrual (line 2 minus line 1).	\$	16,223	3	
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	253,850	4	
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5	
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	270,073	7	

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	164,563	8		FOR OFF USE ONLY	
	1996	215,104	9			
	1997	217,978	10	13	FROM R. E. TAX STATEMENT FOR 1999	\$
	1998	214,416	11	14	PLUS APPEAL COST FROM LINE 5	\$
	1999	241,423	12	15	LESS REFUND FROM LINE 6	\$
1999 Real Estate Tax Bill	241,423			16	AMOUNT TO USE FOR RATE CALCULATION	\$
Estimated Increase	1.05%					
2000 Estimated Taxes	2,534.94					
Use	253,850					

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

A. Square Feet: 109,175

B. General Construction Type:

Exterior Brick

Frame Steel

Number of Stories 3

C. Does the Operating Entity?

☐

 (a) Own the Facility

☒

 (b) Rent from a Related Organization.

☐

 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

 (a) Own the Equipment

☒

 (b) Rent equipment from a Related Organization.

☒

 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

 YES

☒

 NO

If so, please complete the following:

1. Total Amount Incurred: N/A

2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A

4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	270,508	1991	\$ 404,280	1
2	Resident Care		1996	287,781	2
3	TOTALS	270,508		\$ 692,061	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning:

01/01/00

Ending:

12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	235		1991	1991	\$ 8,276,993	\$	40	\$ 206,925	\$ 206,925	\$ 1,896,813	4
5	10		1994	1994	31,090	987	40	777	(210)	5,439	5
6	53		1996	1996	2,505,079		40	62,627	62,627	281,822	6
7											7
8											8
	Improvement Type**										
9	1992 Improvements			1992	32,614	1,035	20	1,631	596	13,737	9
10	1993 Improvements			1993	2,750	88	20	138	50	1,035	10
11	1993 Improvements			1993	4,822	156	40	121	(35)	907	11
12	1994 Improvements			1994	6,432		10	643	643	4,180	12
13	1995 Improvements			1995	18,192		20	910	910	5,005	13
14	1995 Improvements			1995	12,681	403	10	1,268	865	6,974	14
15	Electric Exterior Sign			1996	7,820	200	10	782	582	3,519	15
16	New Doors			1996	1,475	38	10	147	109	661	16
17	Hot Water Tank			1996	3,847	99	10	385	286	1,732	17
18	Landscaping			1996	13,490	346	10	1,349	1,003	6,071	18
19	Repaving Parking Lot			1996	7,412	190	10	741	551	3,335	19
20	Replace Irrigation System			1996	27,077	694	10	2,708	2,014	12,186	20
21	Walk in Freezer			1996	29,923		10	2,992	2,992	13,464	21
22	Landscaping			1997	17,283	864	10	1,728	864	6,048	22
23	Outside Parking Lot Lighting			1997	2,102	54	10	210	156	735	23
24	Nurse Call Station Extension Work			1997	3,310	85	10	331	246	1,159	24
25	Remodeling Work - Windsor Hall			1997	3,500	89	40	350	261	1,225	25
26	Basement Remodeling - Street Village Décor			1998	31,614	1,622	39	790	(832)	1,975	26
27	Remodeling Work - Day Care Area			1999	16,638	426	39		(426)		27
28	Remodeling-Ice Cream Parlor			2000	3,624	46	39	46		46	28
29	Remodeling Work-3rd Floor Hamilton Unit			2000	16,421	211	39	211		211	29
30	Remodeling Work-Nurses Stations (All Floors)			2000	20,103	258	39	258		258	30
31	Plumbing/Electrical Work-Boiler Room (Basement)			2000	4,587	59	39	59		59	31
32	Remodeling Work-Dialysis Room			2000	7,253	93	39	93		93	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				\$ 11,108,132	\$ 8,043		\$ 288,220	\$ 280,177	\$ 2,268,689	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 1,883,219	\$ 68,312	\$ 175,545	\$ 107,233	5-10	\$ 1,323,627	37
38	Current Year Purchases	44,590	6,307	2,305	(4,002)	5-10	2,305	38
39	Fully Depreciated Assets	81,470					81,470	39
40	Allocated from Mgmt Co.			234	234		234	40
41	TOTALS	\$ 2,009,279	\$ 74,619	\$ 178,084	\$ 103,465		\$ 1,407,636	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Van	1998 Ford E350 Van	1998	\$ 40,790	\$ 8,951	\$ 13,597	\$ 4,646	3	\$ 33,992	42
43	Resident Passenger Van	2000 Chevrolet Express	2000	29,261	5,852	4,877	(975)	3	4,877	43
44		Van								44
45										45
46	TOTALS			\$ 70,051	\$ 14,803	\$ 18,474	\$ 3,671		\$ 38,869	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 13,879,523	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 97,465	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 484,778	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ 387,313	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 3,715,194	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Company				7,842			6
7	TOTAL				\$ 7,842			7

8. List separately any amortization of lease expense included on page 4, line 34.
 This amount was calculated by dividing the total amount to be amortized
 by the length of the lease N/A
N/A

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 9,305 Description: Ice Machine-\$360; Offsite Storage-\$2,629; Copier \$6,316
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19			N/A		19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning _____
 Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2001</u>	\$ _____
13.	<u>/2002</u>	\$ _____
14.	<u>/2003</u>	\$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>40</u>
		HOURS PER AIDE <u>86</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies	<u>750</u>	<u>1,000</u>		1,750
3	Classroom Wages (a)				
4	Clinical Wages (b)	<u>2,082</u>	<u>8,800</u>		10,882
5	In-House Trainer Wages (c)	<u>2,107</u>	<u>2,809</u>		4,916
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		<u>2,000</u>		2,000
9	TOTALS	\$ 4,939	\$ 14,609	\$	\$ 19,548
10	SUM OF line 9, col. 1 and 2 (e)	\$ 19,548			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>40</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	<u>30</u>
2. From other facilities (f)	
TOTAL TRAINED	70

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist	L10A, C1	3022	hrs	\$ 70,590		\$	\$	3,022	\$ 70,590	1
2	Licensed Speech and Language Development Therapist	L10A, C1,C3	893	hrs	25,562	332	13,271		1,225	38,833	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	L10A, C1,C2	3979	hrs	116,010			14,456	3,979	130,466	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts				314,923		314,923	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							
10				hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				\$ 212,162	332	\$ 13,271	\$ 329,379	8,226	\$ 554,812	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending:

12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 800,788	\$ 828,070	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	2,453,432	2,453,432	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	302,840	302,840	6
7	Other Prepaid Expenses	19,833	19,833	7
8	Accounts Receivable (owners or related parties)		3,680	8
9	Other(specify): <u>Interest Receivable</u>		1,230	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,576,893	\$ 3,609,085	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		692,061	13
14	Buildings, at Historical Cost		10,751,084	14
15	Leasehold Improvements, at Historical Cost	271,511	357,048	15
16	Equipment, at Historical Cost	962,997	2,079,330	16
17	Accumulated Depreciation (book methods)	(794,652)	(3,715,194)	17
18	Deferred Charges		15,139	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify): <u>Loan Costs</u>		38,696	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 439,856	\$ 10,218,164	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,016,749	\$ 13,827,249	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 317,915	\$ 317,915	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,500,000	1,500,000	29
30	Accrued Salaries Payable	261,360	261,360	30
31	Accrued Taxes Payable (excluding real estate taxes)	20,400	20,400	31
32	Accrued Real Estate Taxes(Sch.IX-B)		253,850	32
33	Accrued Interest Payable	8,429	8,429	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	975,521	573,585	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,083,625	\$ 2,935,539	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	19,374	19,374	39
40	Mortgage Payable	1,250,625	13,992,563	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43		275,407	275,407	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,545,406	\$ 14,287,344	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,629,031	\$ 17,222,883	46
47	TOTAL EQUITY (page 18, line 24)	\$ (612,282)	\$ (3,395,634)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,016,749	\$ 13,827,249	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Butterfield Health Care, Inc.
d/b/a Meadowbrook Manor
Provider #0037366
12/31/2000

Schedule 17A

XV. Balance Sheet
Current Liabilities
Line 36 - Other Current Liabilities

	Operating	After Consolidation
Resident Credit Balances	477,406	477,406
Accrued Rent	401,936	
Miscellaneous Accruals		
Due to Related Party	96,179	96,179
Total Line 36 Other Current Liabilities	<u>975,521</u>	<u>573,585</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 687,794	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 687,794	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(378,968)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(921,108)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (1,300,076)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (612,282)	24 *

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 12,848,725	1
2	Discounts and Allowances for all Levels	(1,438,283)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 11,410,442	3
B. Ancillary Revenue			
4	Day Care	38,457	4
5	Other Care for Outpatients		5
6	Therapy	824,868	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 863,325	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	14,155	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35,131	13
14	Non-Patient Meals	659	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	314,923	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,734	19
20	Radiology and X-Ray	11,520	20
21	Other Medical Services	308,590	21
22	Laundry	10,875	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 708,587	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	9,119	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9,119	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Wheelchair Rental Income	4,331	28
28a	Bedhold and Other Income	3,016	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 7,347	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 12,998,820	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,882,376	31
32	Health Care	5,115,094	32
33	General Administration	1,898,741	33
B. Capital Expense			
34	Ownership	3,841,446	34
C. Ancillary Expense			
35	Special Cost Centers	481,554	35
36	Provider Participation Fee	158,577	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 13,377,788	40
41	Income before Income Taxes (line 30 minus line 40)**	(378,968)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (378,968)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
See Schedule 19A

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

BUTTERFIELD HEALTH CARE, INC.
D/B/A MEADOWBROOK MANOR
PROVIDER # 0037366
12/31/2000

Schedule 19A

XVII. INCOME STATEMENT

Reconciliation of Net Income (Loss) to Taxable Income (Loss)

Taxable Income (Loss) per 12/31/00 Federal Tax Return	320,926
Section 481 Adjustment	(744,601)
Depreciation	(7,161)
Travel & Entertainment	(4,883)
Political Contributions	(3,249)
Reduction in Bad Debt Allowance	60,000
Net Income (Loss)	<u><u>(378,968)</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Meadowbrook Manor

0037366

Report Period Beginning: 01/01/00

Ending:

12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,937	2,043	\$ 55,419	\$ 27.13	1
2	Assistant Director of Nursing	2,059	2,176	48,207	22.15	2
3	Registered Nurses	40,102	41,246	910,193	22.07	3
4	Licensed Practical Nurses	38,070	39,690	725,623	18.28	4
5	Nurse Aides & Orderlies	156,645	161,201	1,841,584	11.42	5
6	Nurse Aide Trainees	1,885	1,941	10,882	5.61	6
7	Licensed Therapist	7,894	8,412	212,162	25.22	7
8	Rehab/Therapy Aides	11,569	12,263	134,026	10.93	8
9	Activity Director					9
10	Activity Assistants	15,137	15,854	127,211	8.02	10
11	Social Service Workers	9,557	10,136	97,899	9.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	44,944	46,838	416,013	8.88	15
16	Dishwashers					16
17	Maintenance Workers	7,374	7,452	90,339	12.12	17
18	Housekeepers	31,418	32,567	225,687	6.93	18
19	Laundry	12,111	12,542	81,276	6.48	19
20	Administrator	1,878	2,155	79,410	36.85	20
21	Assistant Administrator	1,177	1,413	20,882	14.78	21
22	Other Administrative	2,148	2,266	79,844	35.24	22
23	Office Manager					23
24	Clerical	23,325	24,434	386,975	15.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,632	3,962	39,839	10.06	31
32	Other Health Care: See Schedule 20-A	22,956	24,941	387,029	15.52	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	435,818	453,532	\$ 5,970,500 *	\$ 13.16	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	567	\$ 22,072	L1, C3	35
36	Medical Director	Monthly	12,480	L9, C3	36
37	Medical Records Consultant	Monthly	4,360	L10, C3	37
38	Nurse Consultant	412	25,752	L10, C3	38
39	Pharmacist Consultant	Monthly	6,240	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	82	4,080	L11, C3	44
45	Social Service Consultant	62	3,026	L12, C3	45
46	Other(specify) Quality Assurance	Monthly	2,240	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,123	\$ 80,250		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

XIX. SUPPORT SCHEDULES

A. Administrative Salaries					
Name	Function	%	Amount		
Barbara Erlenbush	Administrator	0.00%	\$ 24,115		
Tamra McDermund	Administrator	0.00%	55,295		
Kathryn Woods	Asst. Administrator	0.00%	20,882		
Robert Jafari	Executive Director	25.00%	49,970		
Nicholas Vangel	Executive Director	20.00%	29,874		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 180,136		
B. Administrative - Other					
Description			Amount		
Butterfield Healthcare Management Group (Eliminated in Column 7)			\$ 28,759		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 28,759		
C. Professional Services					
Vendor/Payee	Type		Amount		
			\$		
	See Attached Schedule 21A		129,216		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 129,216		
D. Employee Benefits and Payroll Taxes					
Description			Amount		
Workers' Compensation Insurance			\$ 138,995		
Unemployment Compensation Insurance			54,372		
FICA Taxes			451,636		
Employee Health Insurance			190,155		
Employee Meals					
Illinois Municipal Retirement Fund (IMRF)*					
Employee Physicals			3,214		
Training & Education			8,897		
Other Employee Benefits			33,203		
TOTAL (agree to Schedule V, line 22, col.8)			\$ 880,472		
E. Schedule of Non-Cash Compensation Paid to Owners or Employees					
Description	Line #		Amount		
			\$		
TOTAL			\$		
F. Dues, Fees, Subscriptions and Promotions					
Description			Amount		
IDPH License Fee			\$ 200		
Advertising: Employee Recruitment			40,028		
Health Care Worker Background Check (Indicate # of checks performed 88)			950		
Illinois Council on Long-term Care			10,797		
Miscellaneous Fees			2,412		
Inspection Costs			3,628		
Dues & Subscriptions			2,427		
Allocated from Management Company			741		
Less: Public Relations Expense		()		
Non-allowable advertising		()		
Yellow page advertising		()		
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 61,183		
G. Schedule of Travel and Seminar**					
Description			Amount		
Out-of-State Travel			\$		
In-State Travel					
Seminar Expense			6,095		
Allocated from Management Company			158		
Entertainment Expense		()		
(agree to Sch. V, line 24, col. 8)					
TOTAL			\$ 6,253		

* Attach copy of IMRF notifications

****See instructions.**

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	6/97	\$ 2,258	3	\$ 376	\$ 753	\$ 753	\$ 376	\$	\$	\$	\$	\$
2	Painting & Decorating	5/98	2,773	3		462	924	924	463				
3	Painting & Decorating	9/99	12,326	3			822	4,109	4,109	3,286			
4	Painting & Decorating	7/00	8,737	3				1,456	2,912	2,912	1,457		
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 26,094		\$ 376	\$ 1,215	\$ 2,499	\$ 6,865	\$ 7,484	\$ 6,198	\$ 1,457	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Meadowbrook Manor

STATE OF ILLINOIS

0037366

Report Period Beginning:

01/01/00

Ending:

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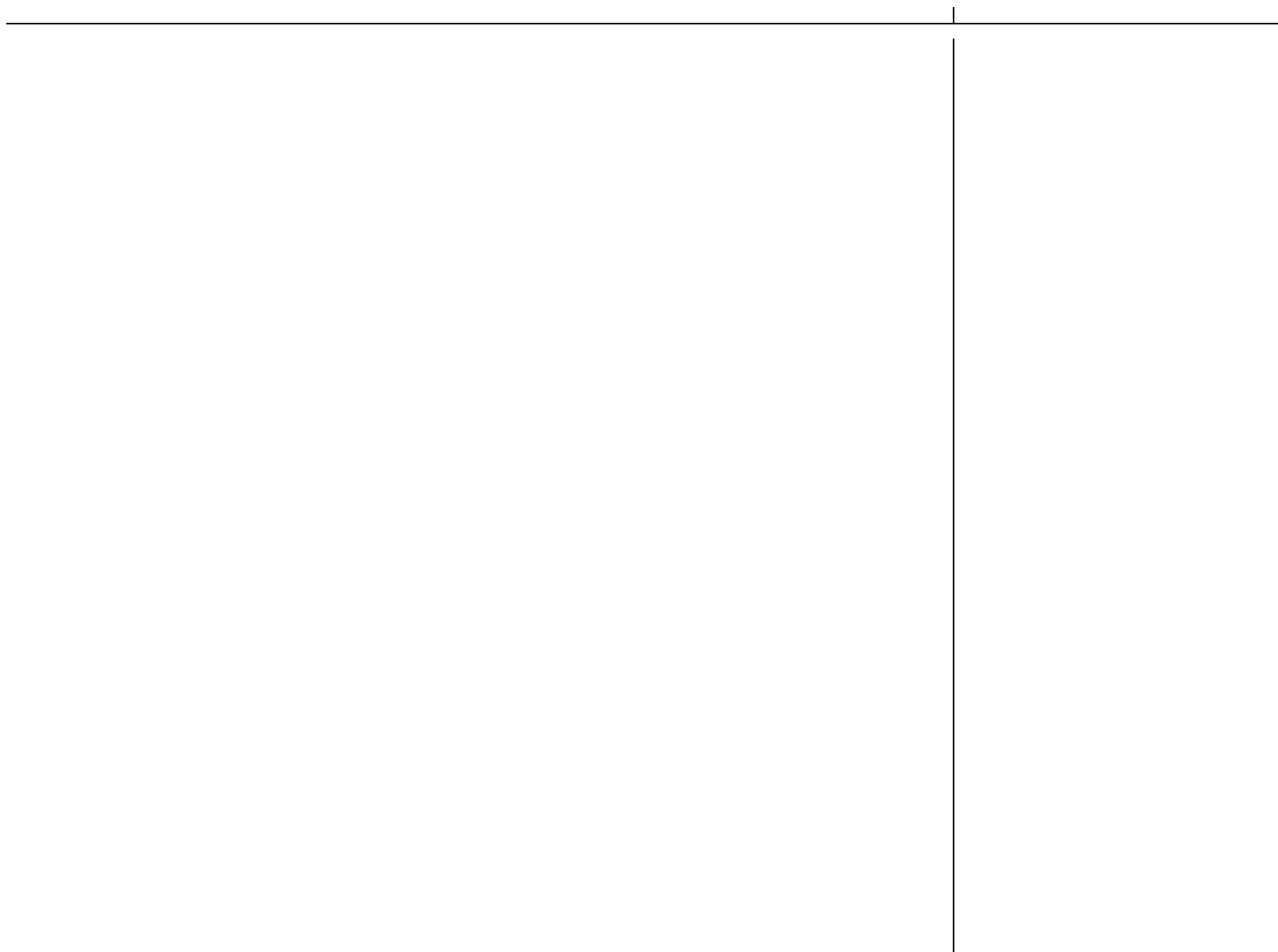
12/31/00

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Council on Long Term Care-\$10,797
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 78,527 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 158,577
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
See Schedule 23A for allocation basis.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 659
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 0%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.



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